Mental Health System Transformation Initiative Implementation

Washington State
Department of Social & Health Services

Community Forum

November 15, 2006

Part 1: Background

Challenges Facing the 2006 Legislature

- Decreasing community psychiatric inpatient capacity
- State hospital waiting lists
- Court rulings in September 2005
  - No wait for transfer of 90/180 ITA patients
  - Failure to follow proper procedures for assessing "liquidated damages"

Part 1: Background (cont'd)

Legislative Approach

- Clarified roles of State & RSNs related to community and state hospital care
- Time limited investment in State Hospital capacity to deal with inpatient access issues
- Investment in enhanced community resources to reduce reliance on state hospitals
- Long term planning

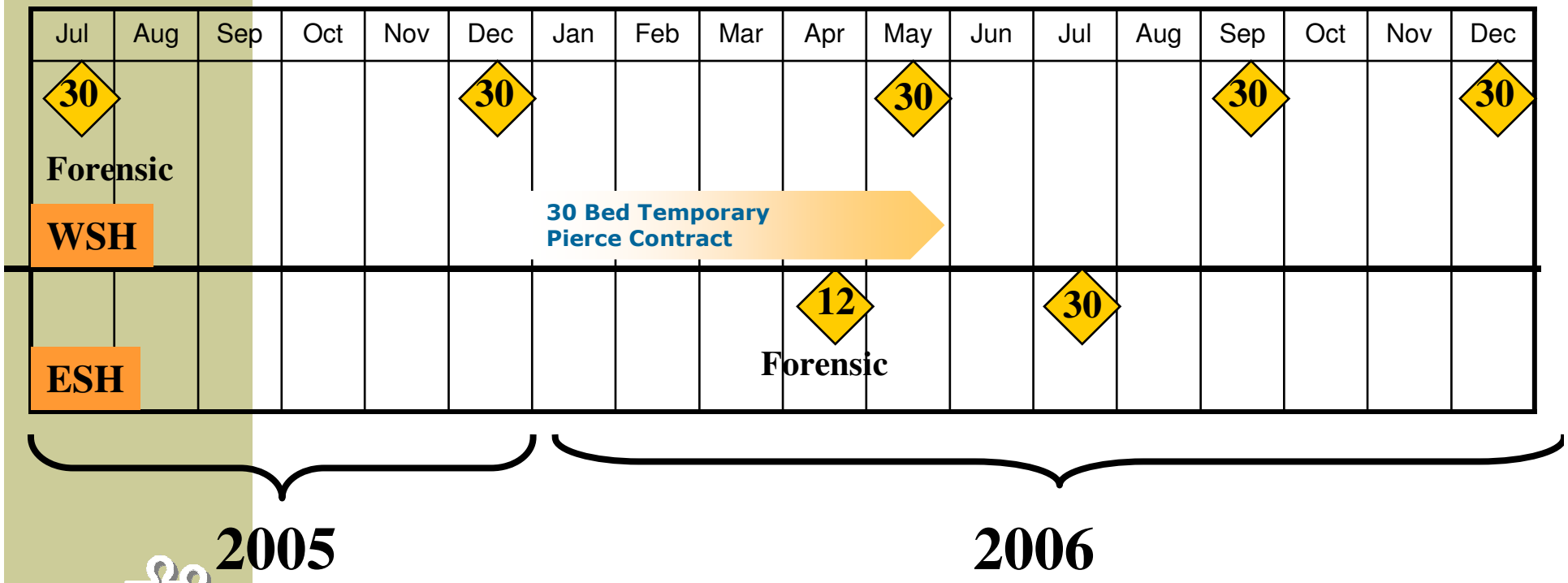
Part 2: Key Provisions of 2SSB 6793 & Budget Initiatives

Responsibility for 90/180 Commitments

- Increased state hospital beds to meet court ruling
- Requires state hospital bed allocation to RSN
- State is financially responsible up to funded capacity
- Directs RSNs pay for exceeding allocated bed days
- Re-directs portion of funds collected by RSNs to other RSNs using less beds than allocated

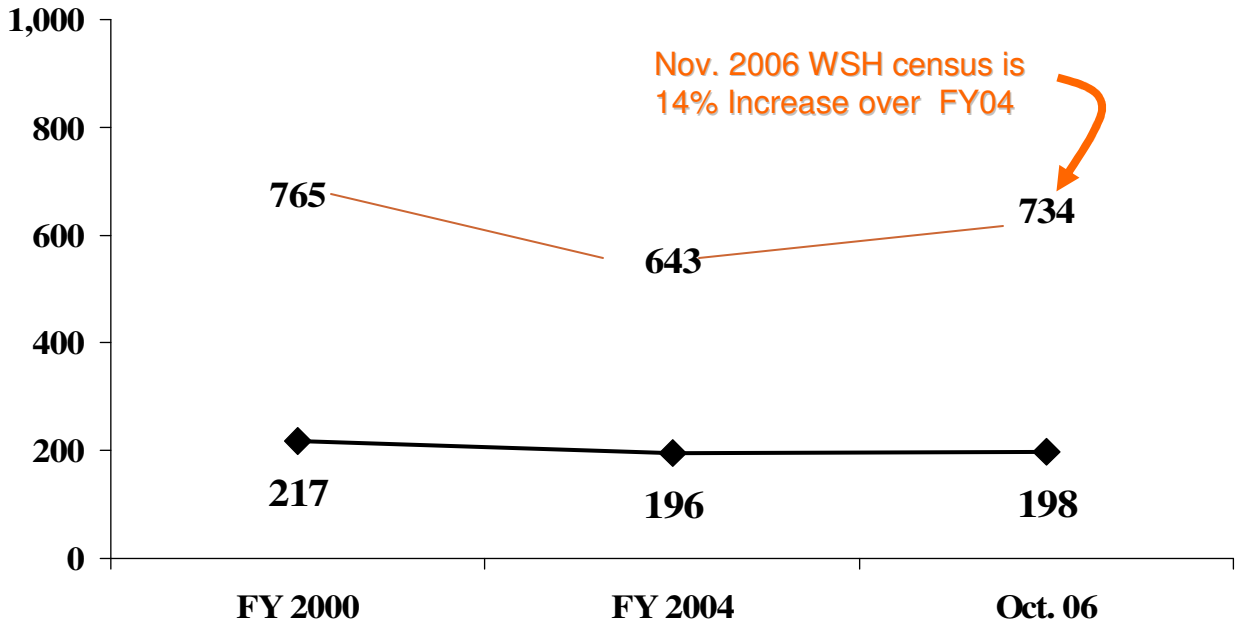
Part 2: State Hospital Changes

State Hospital Increases 2005-2006



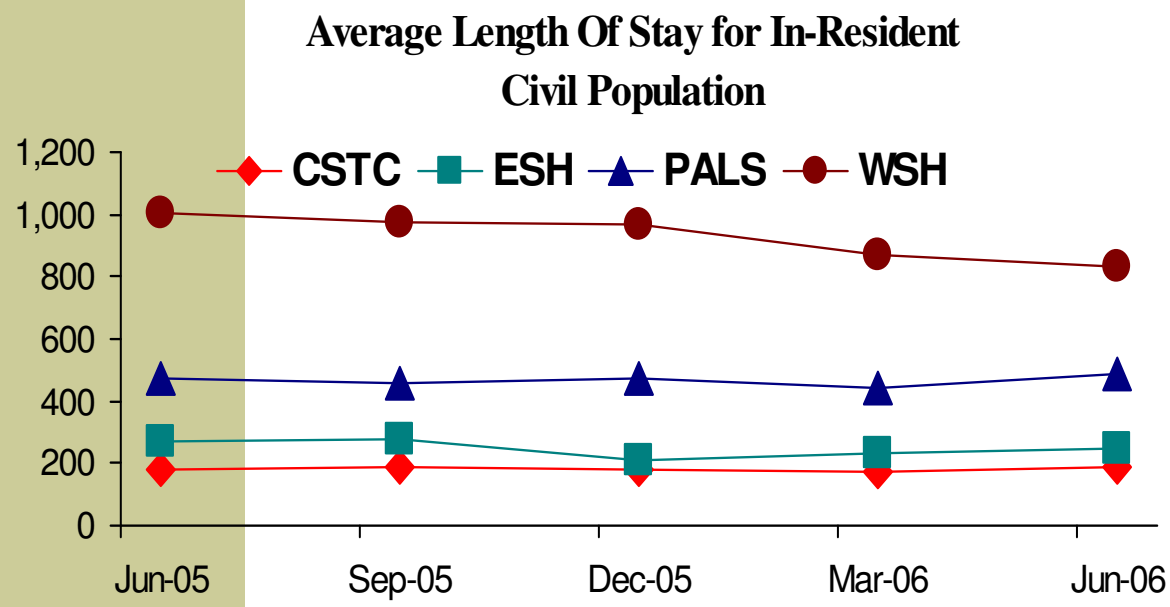
Part 2: State Hospital Changes (cont'd)

State Hospital Census Trends



Objective: Patient Care is Recovery Based and Non-coercive

State Hospital Average Length of Stay for In-Resident Civil Population



	Jun-05	Sep-05	Dec-05	Mar-06	Jun-06
CSTC	179	187	177	170	186
ESH	272	278	211	230	250
PALS	472	457	471	445	485
WSH	1,008	973	970	871	836

Analysis

- **Western average length of stay is 4 times the other hospitals**
- **Average LOS is slowly declining at Western State Hospital**
- **Eastern state hospital's stays may be shorter because it houses more 72 hour and 14-day ITA commitments**

Part 2: Key Provisions (cont'd)

Community Based Care

- Re-states Leg. intent for services to be provided in the community
- Requires RSN to ensure discharge of state hospital patients who no longer require inpatient care
- Raises RSN requirement to manage short term detentions locally from 85-90%
- By January 2008, requires RSNs to pay for individuals at PALS

Part 2: Key Provisions (cont'd)

Community Based Care (cont'd)

- Funding for PACT & other Expanded Community Services
  - Development funds FY 07
  - Operational Funds FY 08
- Long Term Planning - Consultant Contracts
  - Benefits Package/ Rates (TRIWEST)
  - Involuntary Treatment Act (TRIWEST)
  - Mental Health Housing Plan (Common Ground)
  - External Utilization Review (Re-issue RFP)

Part 3: STI Implementation

Process

- Consultants For Each Project Initiative
- Standing Representative Task Force
  - 35-40 members from variety of interested parties
  - Monthly meetings beginning in Oct 06
  - Consumer, family, and advocate representatives
  - Focus groups as needed
- Community Forums
  - 2-3 large forums (approx 150 people) over the next 9 months
  - Today marks the first community forum
- Focus Groups- As needed

Part 3: STI Implementation (cont'd)

Values

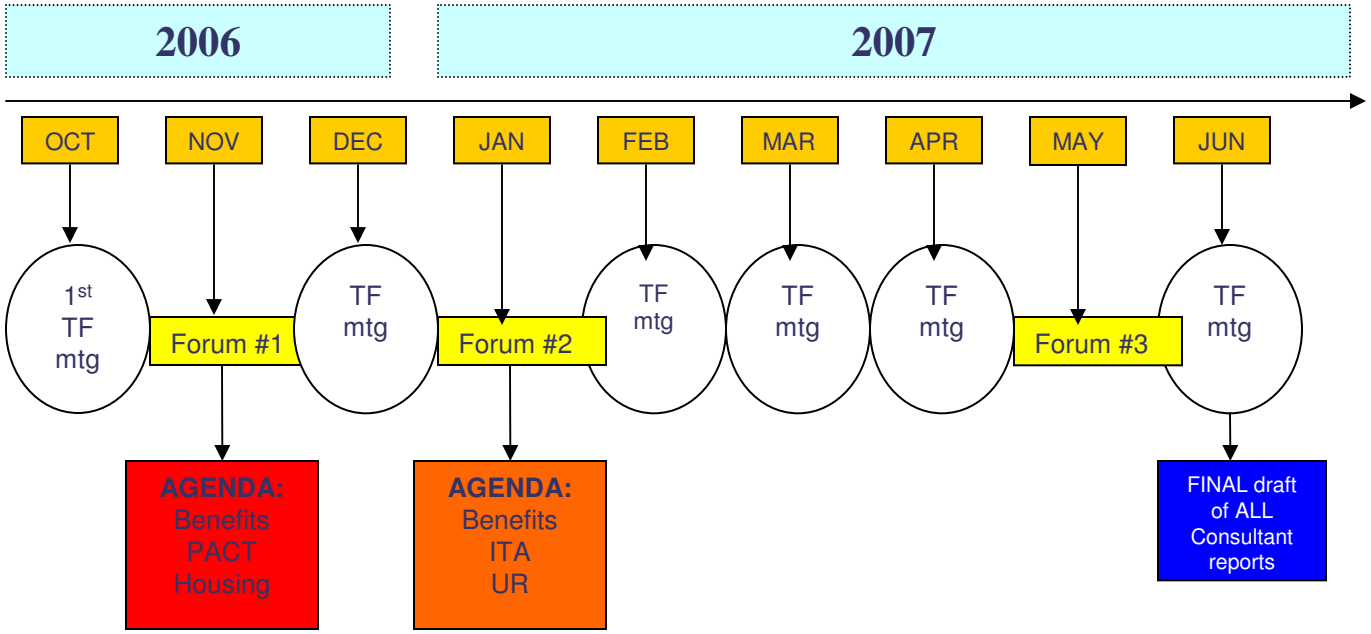
- Participatory Process
- Recovery Oriented
- Evidence Based & Promising Practices/ Cultural Relevance
- Consumer Preferences
- Build on Strengths
- Work within Existing Resources
- Local Governance
- Strive For Consensus
- Address Needs of All Ages
- Respond to Range of Geographic Needs

Part 3: STI Implementation (cont'd)

Consultants

- PACT- WIMIRT (Contract Started Oct 2006)
- Benefits Package- TRIWEST (Contract started Nov. 2006)
- ITA- TRIWEST (Contract started Nov. 2006)
- Housing Plan- Common Ground (Contract started Nov. 2006)
- UR- Re-issue RFP with expected contract mid to late December 2006

STI Task Force & Community Forum Timeline



Part 3: STI Implementation (cont'd)

Role of the Community Forums

- Involve and inform a broad network of stakeholders
- Brainstorm ideas and strategies for Task Force/Consultant consideration

Part 4: MH Benefits Package

FY 07 RSN Funding for Community MH Services

- Medicaid: $305 million
  - Medicaid Waiver services
  - Access to Care Standards
- State only: $105 million
  - Individuals and services not covered by RSNs
  - Inpatient and Crisis services required
  - Outpatient & residential within available resources

Part 4: MH Benefits Package

MH Services Included in Current Medicaid Benefits Package

Brief Intervention Treatment	Individual Treatment Services	Rehabilitation Case Management
Crisis Services	Intake Evaluation	Special Population Evaluation
Day Support	Medication Management	Stabilization Services
Family Treatment	Medication Monitoring	Therapeutic Psychoeducation
Freestanding E&T	MH Services Provided in Residential Settings	Supported Employment
Group Treatment Services	Peer Support	Respite Care
High Intensity Treatment	Psychological Assessment	Mental Health Clubhouse

Part 4: MH Benefits Package (cont'd)

Development of Current Benefit Package

- Mental Health Division compiled information from the RSN's "current practice"
- Goal was to capture all services for the Actuary Study
- Some new innovative modalities were added such as Peer Support and Clubhouse
- Change in interpretation occurred to require "all services provided in all RSN's"

Part 4: MH Benefits Package (cont'd)

Issues with Current Package

- Crisis oriented versus recovery oriented services
- Consistency and availability of services across RSNs
- Rates

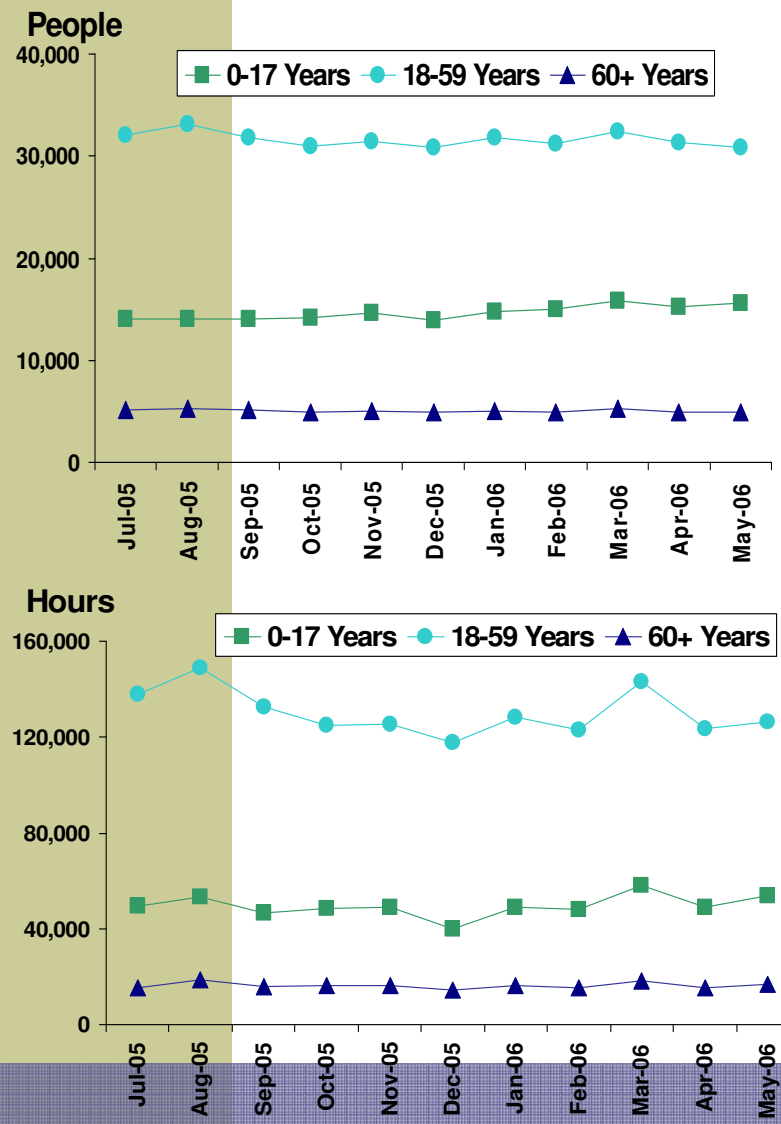
Part 4: MH Benefits Package (cont'd)

Things to Consider as we Move Forward on Benefit Design

- Treatment interventions fit into modalities
- Evidence based practices can fit into the current modalities
- Any changes to the Medicaid State Plan or Access to Care have to be approved by CMS

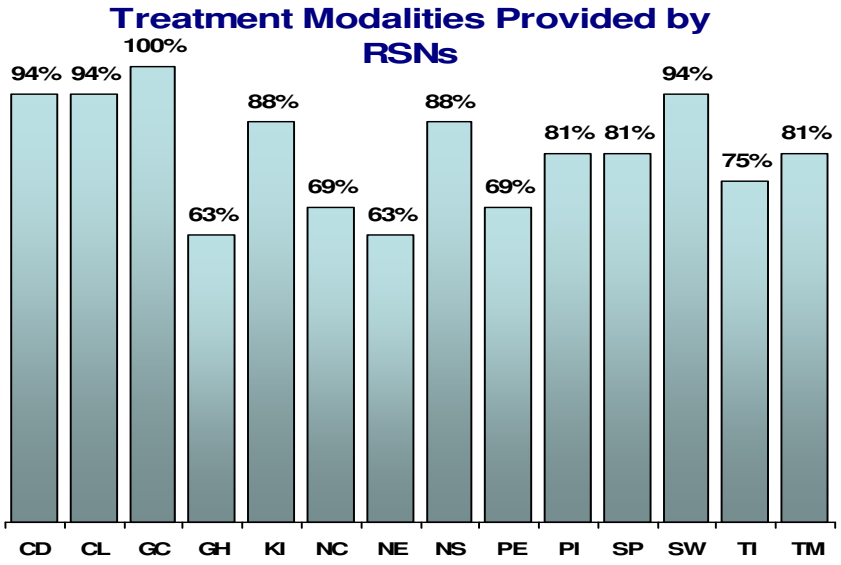
Objective: Care is Recovery Based and Delivered in the Community

Outpatient Services - FY2006



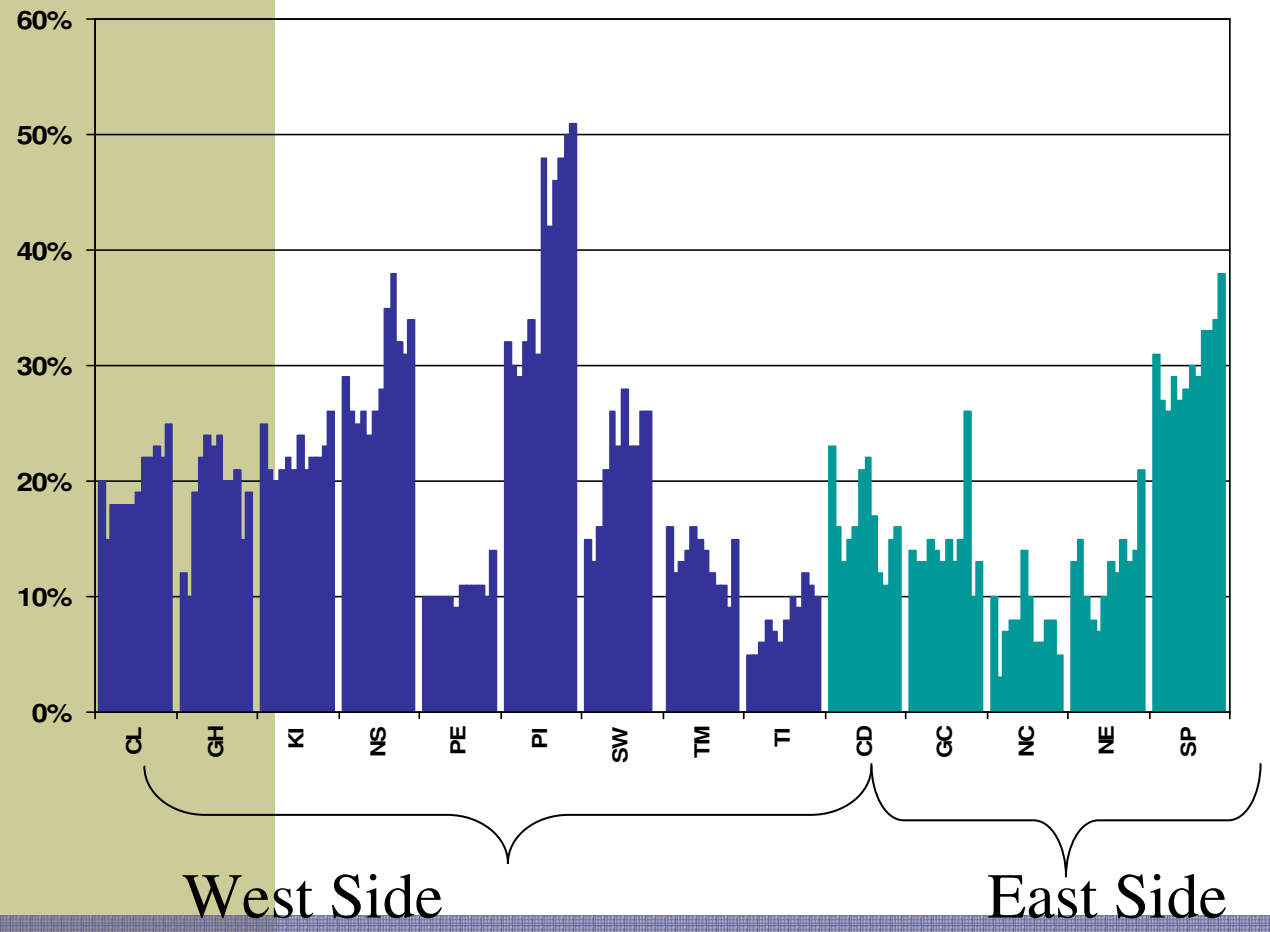
Analysis

- Adults receive the majority of services
- Hours decreasing for adults
- Not all treatment modalities are reported by all RSNs.



Objective: Care is Delivered in the Community

Percentage of Crisis Only Service Hours to Outpatient Service Hours- 2005



Analysis

- The proportion of crisis services delivered varies from 10% to over 50% across the RSN
- For some RSNs, crisis services are the predominate service being delivered.
- For 7 RSNs this trend is increasing
- Reporting may have been inflated in the last half of 2005 because state only funding was prioritized for crisis services

Part 4: MH Benefits Package (cont'd)

Scope of Planning Activities

- Review current menu of required clinical services and supports
- Identify EBPs & Promising Practices for inclusion
- Consider cultural relevance issues
- Develop rate methodology
- Prioritize new benefits menu within allocated resources
- Identify new services to add if additional funding was available

Part 4: MH Benefits Package (cont'd)

Selected Contractor: TriWest Group

- Based in Boulder, CO and Seattle, WA
  - ✓ Helped Clark County, Thurston-Mason RSNs with RFQ/P
  - ✓ Involved in numerous child system collaborations in King, Pierce, Spokane, Thurston and Yakima counties
- Experience with Medicaid Benefit Design issues:
  - ✓ Pennsylvania – Comparison to three other states (AZ, CO, MA); currently helping with State Plan Amendments; promoting recovery/resiliency-oriented and evidence-based services through multi-year reform and development of centers of excellence
  - ✓ Massachusetts – Evaluating "Rosie D" EPSDT reform
  - ✓ Other states – CO, CT, FL, NM, UT

Part 4: MH Benefits Package (cont'd)

Selected Contractor: TriWest Group

- Understand EBPs & Promising Practices, including implementation issues involving cross-cultural applications
  - ✓ Adult EBPs – ACT, IDDT, DBT, SE, Family Psychoeducation, Gatekeeper, MedMAP
  - ✓ Child EBPs – FFT, MST, MTFC
  - ✓ Recovery/Resilience-focused – Wraparound, School-based, Peer Support, Clubhouse, Primary Care Integration
  - ✓ Evidence-based programs vs. practices vs. culture
- Understands current Medicaid funding context
  - ✓ Implications of 1997 BBA, 2005 Deficit Reduction Act
  - ✓ Issues for 1915(b)(3) states (WA, CO, CT, FL, NM, PA, UT) versus 1115 Demonstration states (AZ, MA)

Part 4: MH Benefits Package (cont'd)

Expected Benefits

- Recovery oriented benefits design
- Transparent rate structure
- Prioritize EBPs & Promising Practices / culturally relevant
- More efficient use of service dollars

Part 4: MH Benefits Package (cont'd)

Input from MHTG: Programs & Practices that Best Support Recovery

Illness/Wellness Education	Receiving Peer Support	Parent Partners	Motivational Enhancement Therapy (MET)
Supported Education	Giving Peer Support	Youth Mentors	Dialectical Behavioral Therapy (DBT)
Education for family members	Going to a Drop-In Center	Local community connections	Individual Therapy
Learning to put together a Wellness Recovery Action Plan (WRAP)	Going to a Clubhouse (taking part in the "work order day")	Attending Support Groups	Art Therapy
Crisis Lines	Cognitive Behavioral Therapy	Wraparound process	Massage Therapy
Warm Lines (peer-to-peer telephone support)	Functional Family Therapy	Education in behavioral intervention and crisis management skills	Acupuncture
Getting involved in advocacy	Group Therapy	Skills Training	Learning Self-Help Strategies
Medication Management	Supported Employment	Seeing my psychiatrist	Respite Care
Socialization Opportunities	Grief Counseling	Seeing my psychologist	Counseling for Trauma/Abuse
Day Treatment	Supported Housing	Social Supports	

Part 4: MH Benefits Package (cont'd)

Benefits Package Questions for this Community Forum

- What services and supports are most helpful for people in their recovery?
- What services and supports are not helpful for recovery?
- What services and supports are not provided or are missing from local mental health programs?
- What are the barriers or access issues?

Part 5: Community Resources

Program of Assertive Community Treatment (PACT)

- An evidence-based practice (EBP) for adults with severe and persistent mental illness
- A team-based approach in providing treatment, rehabilitation, and support within the community
- Focus is on working collaboratively with the consumer to address the full range of their biopsychosocial needs

Part 5: Community Resources (Cont'd)

For Whom is PACT?

- Severe and persistent mental illness
  - ✓Priority typically given to schizophrenia-spectrum disorders and bipolar disorder)
- Significant functional impairments
  - ✓e.g., difficulty with maintaining employment and/or housing, meeting medical or nutritional needs
- Continuous high service needs
  - ✓e.g., high use of inpatient or ER services, long duration of substance use, criminal justice involvement

Part 5: Community Resources (cont'd)

How is PACT different from other service models?

- Multidisciplinary staffing
- Team-based approach
- Primary provider of services (vs. brokering)
- Low staff-to-client ratio (1:10)
- Services available 24/7
- Outreach-focused (75%+ services delivered outside of the office)
- Ongoing services to support recovery
- Individualized approach directed to consumer needs

Part 5: Community Resources (cont'd)

PACT Recommended Clinical Staffing per National Standards

Position	Urban (Serves 100-120)	Rural (Serves 42-50)
Team Leader	1 FTE	1 FTE
Psychiatrist	16 hours for every 50 clients	16 hours for every 50 clients
Registered Nurse	5 FTE or at least 3 FTE	2 FTE
Peer Specialist	1 FTE	1 FTE
Master's Level	4 FTE	2 FTE
Other Level	1-3 FTE	1.5 – 2.5 FTE

Note: 1 or more members expected to have training and experience in vocational and substance abuse services

Source: National Program Standards for ACT Teams; Deborah Allness M.S.S.W & William Knoedler, M.D.; June 2003

Part 5: Community Resources (cont'd)

What types of services are provided by PACT Teams?

• Service Coordination	• Activities of Daily Living
• Crisis Assessment & Intervention	• Social/Interpersonal Relationship
• Symptom Assessment & Management	• Leisure Time Skill Training
• Medication (Prescript., Admin., & Monitoring	• Peer Support
• Substance Abuse Services	• Education & Support to Families/Others
• Work Related Services	• Other Support Services

Part 5: Community Resources (cont'd)

PACT Keys to Success

- 90 percent+ fidelity (external fidelity reviews)
- Treatment plans are client-centered
- Services are recovery-oriented
- Non-coercive and non-paternalistic
- Incorporate EBPs and promising practices into individualized service planning
- Cultural competency

Part 5: Community Resources (cont'd)

PACT Outcomes Considered

- Consumer Satisfaction
- State Hospital Utilization
- Community Inpatient Utilization
- Crisis Service Utilization
- ER Utilization
- Housing
- Employment
- Arrests and Incarcerations
- Substance Use

Part 5: Community Resources

PACT Implementation in Washington State

- $2.2 million for PACT development/training in FY 07
- $10.4 Million Per Year to Implement PACT Teams Statewide
- Gradual reduction of recently added state hospital beds

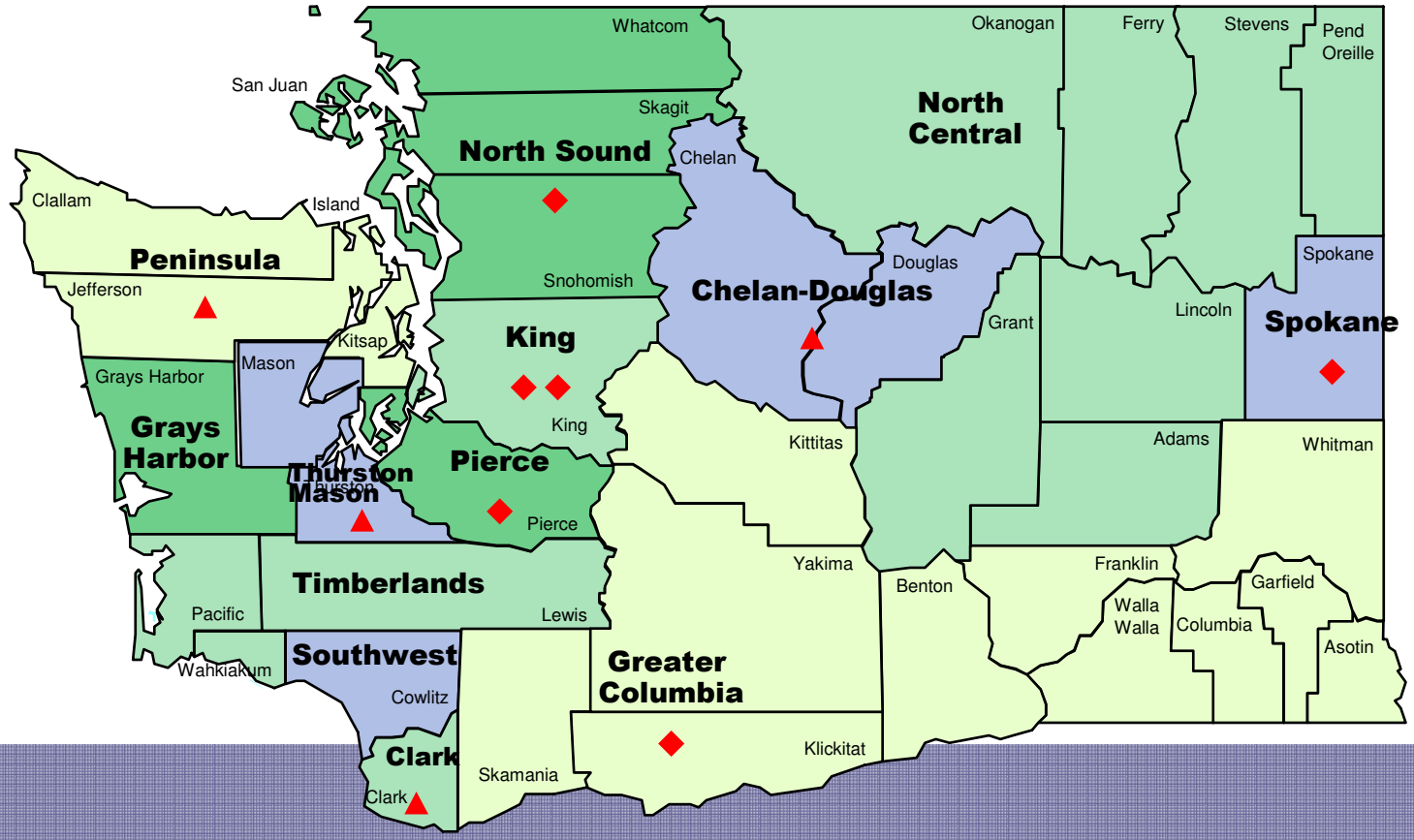
Part 5: Community Resources (cont'd)

13 Regional Support Networks (RSNs)

Effective 9/2006

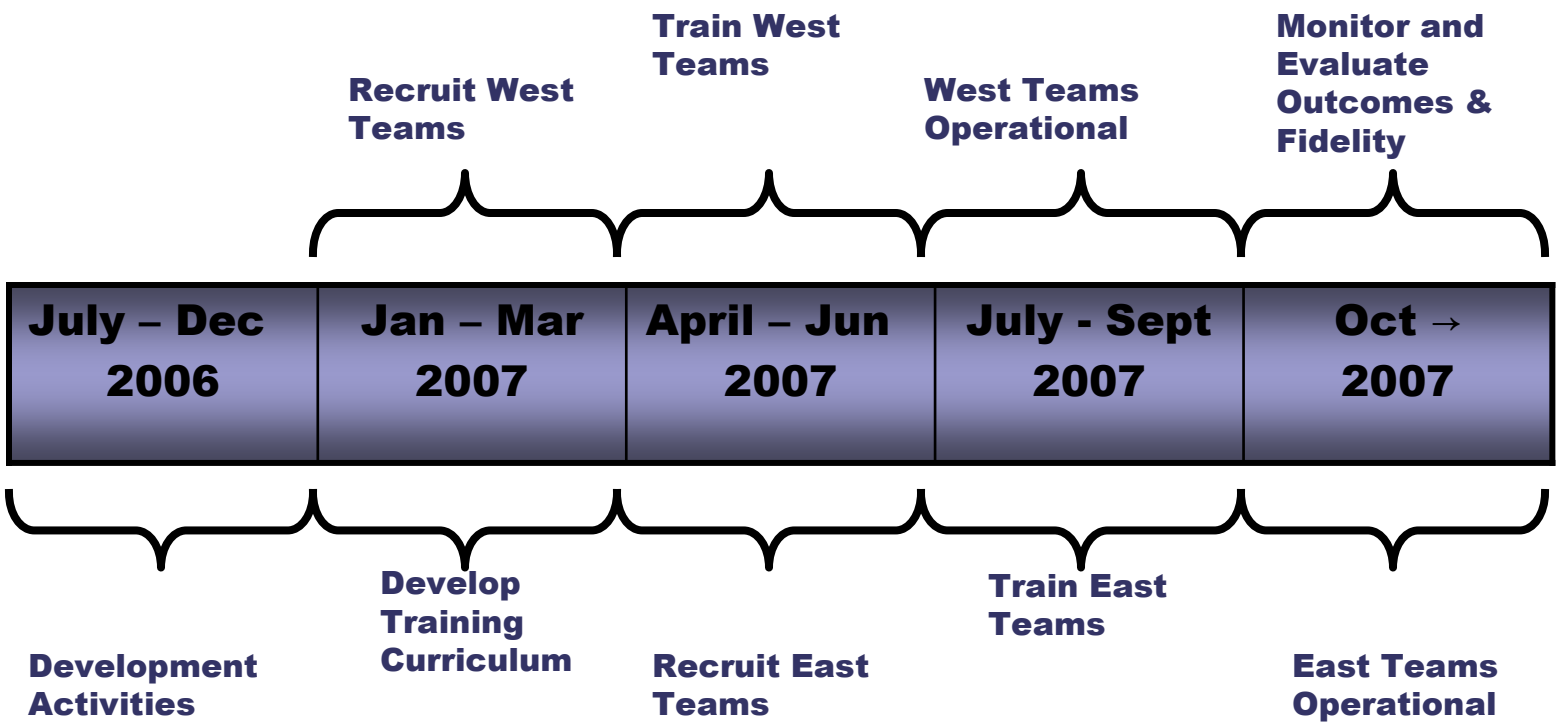
◆ = Full Team

▲ = Half Team



Part 5: Community Resources (cont'd)

PACT Implementation Timeline



Part 5: Community Resources (cont'd)

PACT Questions for this Forum

- What outcomes are most important for PACT?
- What concerns should we be watching for?
- How do we ensure a person-centered, recovery-oriented model within the framework of PACT?

Part 6: State MH Housing Plan

Scope of Planning Activities

- Review RSN housing collaboration plans
- Identify best practices and areas of need
- Develop guidelines for future RSN contracts
- Technical assistance

Part 6: State MH Housing Plan (cont'd)

Expected Benefits

- Improve collaboration with existing planning groups
- Prioritize independent housing which supports recovery
- Increase access to available housing stock by leveraging PACT & ECS services
- Action plan for further housing development

Best Practices in Supportive Housing

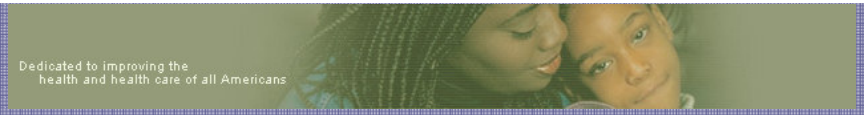
What the people we serve are telling us

"I am not incompetent, I just need help moving the obstacles out of the way"

-- Joseph, A homeless man with co-occurring mental illness and substance use disorders living in a shelter in Seattle.

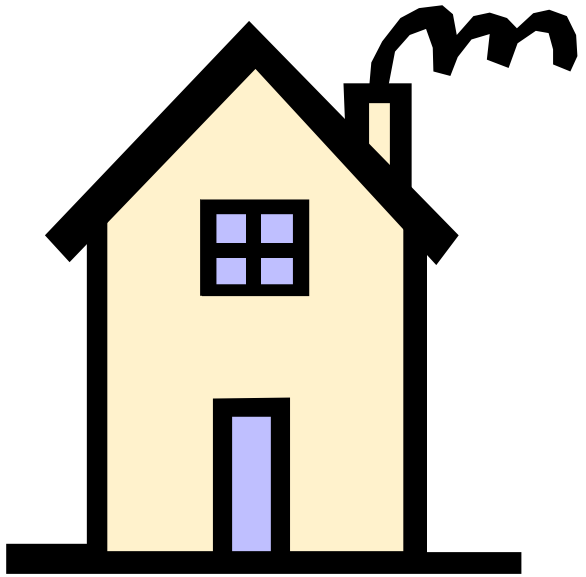
Taking Health Care Home

- Corporation for Supportive Housing Grant
- Demonstrate best practice approaches such as “housing first” to eliminate long-term homelessness
- Align services and funding across multiple systems
- Workforce Development System analysis
- Supported by grants from the RWJF, Bill and Melinda Gates Foundation and United Way of King County



Permanent Supportive Housing (PSH)

Affordable rental housing with supporting services and linkages to treatment without limit on length of residency



Housing and Service Trends

- Moving away from institutional care
- Case management as a treatment modality
- Expansion of permanent supportive housing and downsizing/specialization of group homes
- Development of low-barrier housing: “Housing First”

Move Away from Large Institutions

- Downsizing of state hospitals
- Clinic based care system that was tailored to individuals seeking traditional services
- Creation of board and care homes

Case management as a Treatment Modality

- Shift in Service Packages and Housing
- PACT
- SB 5400: Case managers
- Emphasis on the need for staff to identify and secure housing
- Continuum of housing: higher need clients group homes
- CMHC acquire/develop housing

Expansion of PSH

- CMHC savvy housing development with onsite services
- Clients are now becoming tenants
- Expansion of rental subsidies: Section 8 vouchers, Shelter Plus Care, Supportive Housing Program (SHP)
- Downsizing of group homes
- Specialization of Group Homes: LTR/ARTF

Low-Barrier/Housing First

- System Coordination—funders of services and housing to plan, coordinate, braid and jointly oversee projects
- PSH targeted to high need populations (hospitals, jails, long histories of homelessness)
- Documenting our success at the system level (Culhane)
- Cutting edge: integrating employment and peer supports
- Moving to “Housing First” approach

Housing First Philosophy

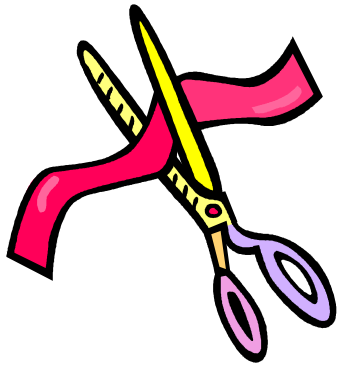
Instead of helping people become

"ready for housing,"

the first priority is to get people housed immediately.

Housing First Core Principles

- It's about us changing the system, not the person
- Consumer choice model
- Clinical services on demand and voluntary

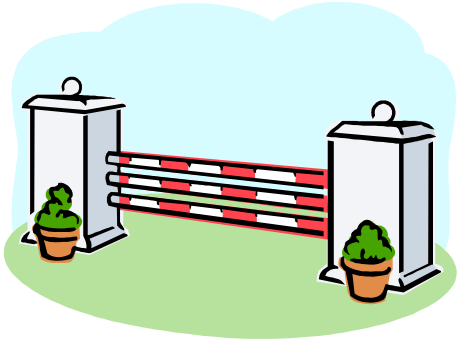


Housing First Core Principles

(continued)

- Low barrier
- Safety emphasis
- Last resort eviction notice
- Peer support with activities

  to build community

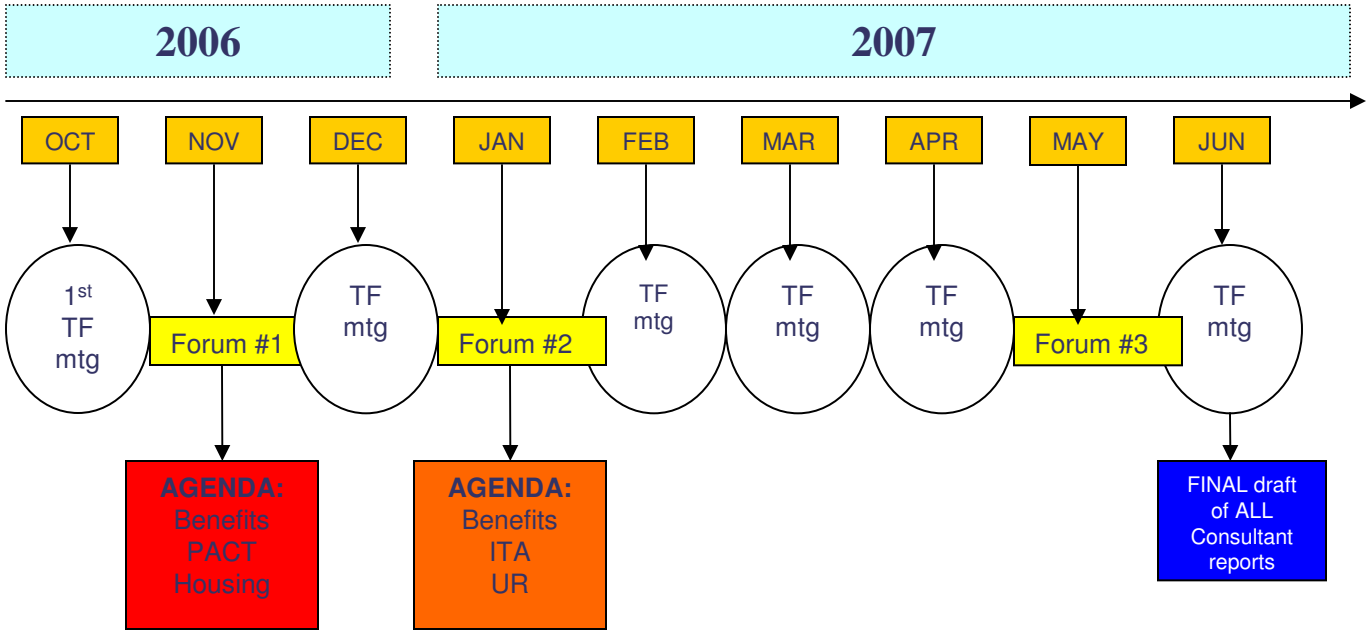


Part 6: Housing Plan (cont'd)

Housing Plan Questions for this Forum

- What supports are needed to obtain and maintain recovery-oriented housing?
- What barriers are there to obtaining and maintaining recovery-oriented housing?
- What housing outcomes should the system measure?

STI Task Force & Community Forum Timeline



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